

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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## PLANNING

There seem to be as many people who disparage the well-meant efforts of our national planners as there are critics of the management of the war. These people live with a horizon just beyond the present. They would like all the paper covered by the ink of visionaries to be converted into explosives and delivered at the enemy immediately. As the foresighted who prepare for war during peace are scoffed at for their pessimism, so those who plan for peace during war earn only criticism for wasting paper, time and energy. Yet had the time already spent on post-war planning been used in preparation for this war our military history would have been less dismal. In the sphere of warfare in which planning was deliberately used we have need to be greatly thankful. Our country is eternally in debt to those who designed our fighter aircraft years before they were put to the test.

Yet those derogatory of planning would be among the first to agree that consolidating the peace is going to be as difficult as winning the war. But they think our planners tend to be only those who have passed the climacteric of their parliamentary or administrative life and are out of date. Planning should not be done by a few, for then if the plan fails there are scapegoats at hand. The decisions about the future are the concern of everybody, then if they do not succeed the nation is at fault. Whether we like them or not we must consider these changes that appear certain to take place. Changes in the medical profession will not occur because the rest of society alters its way of living. Through revolutions, wars, both civil and continental, medical practice has remained fundamentally the same. But now there are many who are showing great anxiety to dictate to the medical profession how it should organise its practice. Unless we consider ourselves better fitted for this task and do it ourselves we will find it done for us. But this is not the sole reason that we should be planning conscious. The Chairman of the Council of

the British Medical Association has written:—

"More than half of the doctors in the fighting forces have no experience whatever of practice, for they were called directly from their hospitals, but even those who were in practice will come back to a new world, we hope to a better world, but certainly to a world of completely altered values. It is for us who have some experience to see that in the world to which they return they have the fullest opportunities for the service to which they have devoted their lives."

Another point, stressed by Lord Dawson, is that medicine is fast becoming more a matter of prevention of disease and of building up the national health than of curative and palliative treatment. The present organisation is too unwieldy to cope with this dual task. In a medical Utopia preventive medicine would be the main subject taught to those about to practice medicine.

Whenever a scheme or reform is proposed, criticism, difficulties and opposition leap to light from what seemed a darkness of apathy and indifference. One has only to have followed the proceedings of the Zoological Society to gather some of the difficulties that beset anyone proposing what seemed naturally right to him. Whereas the reorganisation of other professions and services might mean only the introduction of new ideas, medicine demands that one great principle should be retained for all time. It must never be forgotten that a patient is a human being. Call it the doctor-patient relationship, call it plain humanity, call it what you will, but remember that medicine is not a cold, inhuman science and that the bond between doctor and patient cannot be defined. No doctor can agree with Madame Curie that in science we must be interested in things, not in persons. With Sir Beckwith Whitehouse we should hope that:—

"Neither the people of this country nor the bulk of the medical profession desire to become the regimented units of a system of

bureaucratic control. . . . The British public at heart dislikes communal methods of treatment, however efficient they are."

After consideration of the patient any new medical reorganisation should attend to the needs of the doctor himself. All doctors should have freedom for a definite time from their routine work in order that research can be undertaken. The argument that although research is primarily done in the laboratories, the testing of the results is in the hands of the physician, is still true. No doctor should be so worked that he has not time for examination of his results or for following recent advances.

In the light of these few remarks we come to the Draft Interim Report, prepared by the Medical Planning Commission, lately put before the British Medical Association. The Commission has put forward recommendations for the future of medicine to be freely discussed by the profession; they are in no way final decisions. The Report recommends a central health authority to be set up which would have purely a controlling function. This central body is to be of the corporate nature as proposed by Lord Reith. It would control a number of health centres distributed throughout the country to which general practitioners would be attached. The administration of the preventive

medical services would be carried out from the regional centres by a committee of qualified medical men and non-qualified men with experience in public health. All voluntary and council hospitals would be co-ordinated under the central scheme. Specialists would hold positions in the hospitals and would visit the health centres when required. Salaried appointments would be either whole or part-time, for the proposal of a whole-time Government medical service is not advocated.

This is necessarily a brief summary of the form that provision for the nation's health is taking in the minds of our planners. Whether or not the scheme fulfils the desiderata of the ideal medical service depends on how it is supported by the profession and how it works in practice. It may also depend on the nature of the Government in power after the war and whether money can be found to build the numerous centres needed. Yet it is at least a signpost to the glorious new world now being born in the smoke from our guns. Idealism, which has been the hall-mark of youth, is either spreading beyond its confines, or else our leaders are becoming younger in spirit. The mountains are in labour, but they must bring forth more than a single laughable little mouse.

## CORRESPONDENCE

*To the Editor, St. Bartholomew's Hospital Journal.*  
Dear Sir,

In reading your editorial "Polemic" in the August JOURNAL, I remained very foggy as to its meaning until I approached the end, when I perceived that you were violently attacking "government financed medical research." I remain doubtful whether the opinions expressed were based on a complete ignorance of the facts about medical research in Britain, or whether—which would be worse—they were deliberate distortions of the truth designed to stimulate controversy in your columns.

Most of the state-financed medical research in Britain is carried out under the Medical Research Council. This body, thanks largely to the wisdom of the late Sir Walter Fletcher, its first secretary, has a constitution under the Privy Council which virtually frees it from any political interference. I recommend you, Sir, and other critics of this viper in our midst (as you seem to conceive it), to read Sir Edward Mellanby's 1938 Harveian oration on "the State and Medical Research."\* If you go further and study the annual reports of the M.R.C. of the last 20 years, you will find it hard to deny that state-financed research has made worthy contributions to medical knowledge and that these contributions have covered subjects of fundamental importance as well as those capable of immediate practical application.

I myself have worked for the M.R.C. for over

fifteen years. In that time I have been able to study, amongst other things, the diameters of bacteriophages—without interference by anybody "scentsing the winds of a coming election." Even when I investigated the serological relationships of fowl-tumour viruses, it was never hinted to me that persistence in these studies might alienate votes in agricultural constituencies.

In your august opinion, Sir, do we need more medical research, or less? If the former, who in thunder is going to pay for it if the State does not? Do you think that commercial firms financing research can be relied upon to be entirely disinterested? or that private donors—if any remain after the war—are always wisely guided as to how they dispose of their money? Perhaps you are unaware that shortly before the war plans were under way for extensive long-term researches in chemotherapy, and that these were being state-financed because no other possible donors of funds were willing to spend money on a project which was not guaranteed to yield immediate returns.

I am,  
Yours, etc.,  
C. H. ANDREWES.

\* "Lancet," 1938, ii, p. 929.

34, Ossulton Way, N.2.  
August 20th, 1942.

## HYDRONEPHROSIS, HÆMATURIA AND FOOTBALL

By AIR COMMODORE G. L. KEYNES,  
R.A.F.V.R.

Hydronephrosis is already "on the list" (though I deprecate the compilation of lists) of "causes of painless haematuria." I have never noticed, however, any reference in literature—while admitting that I have never properly searched for it—to an association between hydronephrosis, haematuria and minor injury. My attention was first directed to this matter many years ago (1928) when I was called in the small hours of a winter's morning to the Hospital to see a junior medical student, aged 20, who was reported to be apparently dying. It appeared that two days earlier he had received a slight injury while playing football, the result of a charge, not of a kick. The injury was so slight that he took no notice of it until later in the day, when he had pain on the side of the injury and noticed that his urine was bloodstained. The bleeding was still present on the next day, and his family doctor arranged for his admission to Hospital, though, perhaps doubting whether the injury was really the cause of the bleeding, he put him in the ward of one of the physicians. He did not appear to be seriously ill, and he remained in the medical ward for twenty-four hours, still passing bloodstained urine in small quantities. A progressive deterioration in his condition was somehow overlooked until the early hours of the morning of my call, when he was found to be extremely ill and in urgent need of surgical attention. When I reached the hospital, the patient was obviously *in extremis*. He was pulseless, pale and restless, and in addition to showing all the signs of acute blood-loss was in an agony of pain such as I have seldom seen. The other clinical facts at this time were confusing. He made no complaint of any pain on the side of the supposed injury, and there was no evidence of any retroperitoneal haemorrhage such as might have been expected, for delayed symptoms after partial rupture of a kidney are by no means unknown. On the other hand, he had complete retention of urine, and his bladder was distended almost up to his umbilicus; yet catheterization produced nothing but a tiny quantity of almost pure blood. It seemed that his agony was due mainly to the extreme distension of the bladder, but there was no time for deep thought, and the first necessity was clearly a blood transfusion. A passing night-dresser was seized and grouped,

and a first transfusion of 700 ccm. of citrated blood was started. The patient was then anaesthetized, and preparations were made for removal of the kidney on the side of the alleged injury, in the absence of evidence indicating any other source of haemorrhage. Confidence in the diagnosis was not increased by the discovery that the kidney showed no sign of rupture of the capsule, and was not enlarged; it appeared, in fact, to be perfectly normal. Nevertheless, it was removed as quickly as possible, and the wound closed. By this time, further blood donors had been assembled, and when the patient was turned on his back, after the completion of the nephrectomy, a second transfusion of 700 ccm. was given. It now remained to deal with the bladder distension, if necessary by suprapubic cystotomy. Passage of another catheter produced no urine, and it was then surmised that the bladder might have been filled with blood by a slow trickle from the kidney in a concentration sufficient to cause clotting. To test this theory, a Bigelow's evacuator was introduced, and the force of the stream of water from the rubber bulb proved to be enough to break up the clot, which was ultimately removed entirely. As this solid clot completely filled the bladder up to the level of the umbilicus, its bulk must have represented at least two pints of pure blood. When the bladder was empty, a third transfusion of 700 ccm. was given, and the patient was returned to bed in as good a condition as could be expected. He had been for almost three hours in the operating theatre while he was subjected to drastic surgical measures, but he had received over two litres of blood by transfusion, and the bladder distension, which was partly responsible for his original state of "shock," had been relieved. Also, he was young and fundamentally quite healthy. His subsequent recovery was slow, being delayed by a cystitis and pyelitis affecting the remaining kidney, due no doubt to the instrumentation necessary for removal of the blood clot. In the end, however, he regained his health completely and, after many arduous years in medical practice, is at the present moment working as a member of a mobile surgical team in the Libyan desert. This he has been doing for nearly a year, thus providing evidence that a man with a single healthy

kidney is as good as anyone else with two. Renal function tests carried out two or three years after his recovery, had shown that his renal efficiency was above normal. The kidney which had been removed was protected from the curiosity of the mob, and was not investigated until it had been properly hardened. It proved to be the site of an early "idiopathic" renal hydronephrosis, and was added to the collection of specimens in the College Museum (Q.146b).

My experience with this patient made a deep impression on my mind, and I was always thereafter on the look-out for a similar combination of circumstances. Some thirteen years passed, however, before any comparable event came to my notice. In the autumn of 1941 an airman, aged 24, was injured at football, receiving a blow in the front of the right loin. He was admitted to a R.A.F. Hospital with haematuria, which persisted in diminishing amount for ten days. The bleeding was not so urgent that immediate operation on the kidney was called for, since it is not uncommon for bruising of a kidney to cause a temporary haematuria without any serious consequences. In this instance, the patient had no further symptoms of any kind, though a precautionary excretion-pyelogram was done two months after the injury. No shadow was obtained on the side of the injury, and an injection pyelogram confirmed the conclusion that the kidney was abnormal, some difficulty being experienced in filling the pelvis, and dilatation of the calyces being seen. A diagnosis of hydronephrosis following injury was made and nephrectomy advised. The kidney was accordingly removed, and proved to be the seat of an advanced "idiopathic" hydronephrosis of the pelvic type. It did not show any external evidence of injury, but it was not cut open and, being of exceptional interest, was sent to Professor Hadfield. It was clear that the abnormality of the kidney preceded the injury, and provided a second example of the triple association which forms the heading of this article.

A third example was not long in appearing, though the clinical picture on this occasion was quite different from the last. An airman, aged 19, under training for air-crew duties, who had been recently examined by a medical board and passed as "fit," received a blow on the right side of the abdomen from an opponent's knee while playing football. The injury did not appear serious at the time, but soon afterwards some blood was noticed in his urine, and he complained of abdominal pain.

He was admitted to a R.A.F. Hospital where it was found that his abdomen was uniformly distended, with tenderness on the right side and some rigidity. His temperature was raised to 103° and his pulse was rapid. There was some suggestion of a fluid thrill in the abdomen, though this was difficult to elicit owing to the tenderness and rigidity. He was presented to me as probably having peritonitis due to a ruptured viscus and as a candidate for immediate laparotomy. He was obviously very ill, but I did not find sufficient tenderness or rigidity in his rather tumid abdomen to warrant a diagnosis of peritonitis; neither did he show signs of acute blood loss. I therefore advised against immediate action. On the following day he was more ill, with no material change of the signs. Some action had to be taken, though I was still of the opinion that he had not got peritonitis. The haematuria had been a minor feature, but its presence influenced my decision to limit the operation to exploration of the right kidney through the ordinary renal incision, catheterization having proved that there was no injury to the bladder. This exploration revealed an enormous hydronephrosis which seemed to fill the whole abdomen. There was a small amount of blood-clot behind it, without any sign of infection, or of extravasated urine. There was, in fact, still no explanation of the patient's pyrexia and rapidly increasing condition of "shock," and it was clearly impracticable to attempt removal of the diseased kidney. The sac of the hydronephrosis was therefore drained, over seven pints of blood-stained urine being removed, and the patient was returned to bed with so rapid and feeble a pulse that it seemed doubtful whether he would survive for long. Though there was no proof that he had lost much blood, he was given a blood transfusion and this measure of resuscitation was followed by a gradual recovery, though the tachycardia persisted for some time. It was intended that the drainage of the hydronephrosis should be continued until the patient was well enough for its removal to be effected, but the large tube which had been introduced, came out after a fortnight's drainage and could not be replaced. This misfortune was followed by a rapid enlargement of the abdomen due to refilling of the cavity with pus and drainage had to be re-established by operation. The patient's general condition then steadily improved, until two months after the initial operation it was judged safe to attempt a nephrectomy. This was difficult owing to peritoneal adhesion to

the hydronephrotic sac over a very large area, but it was safely accomplished, the specimen showing a pelvi-renal hydronephrosis of enormous size. After a normal convalescence, the patient has now returned to his training course. His only anxiety throughout his illness was lest he should be disqualified for further training, but this fear has not been justified by the event, and he is, indeed, more truly "normal" at the present moment than when he was passed fit for active service a year before.

**Summary**—Little emphasis has hitherto been laid on the association between hydronephrosis, haematuria, and minor injury. In the present

article three examples of this association are described, the injury in each instance having been received during a game of football. The hydronephrosis was of the renal, pelvic, and pelvi-renal type in the respective patients. The clinical picture was somewhat bizarre in the first and third, the haematuria being very severe in one and relatively slight in the other. Hydronephrosis of the "congenital" or "idiopathic" type is common in young men, and haematuria, severe or mild, following minor injury should suggest the possible presence of this abnormality which may, as in two of these three instances, have extremely serious consequences.

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## CYPRUS

*From a Correspondent*

I think the time has come when I can give you some impressions of Cyprus, which, as you have no doubt guessed, was my temporary home for no inconsiderable time. Let it be understood that what I write is my own opinion, and if I paint an unduly rosy picture of this island, it is because I was fortunate enough to see it and its people in a favourable light. Many others have little good to say of the people and give but grudging praise to the beauty of the country. Admittedly, the people are not by any means perfect and, in the towns particularly, are quarrelsome and thieving; and discipline is so hard to instil that the men do not make good soldiers.

There is a big Greek preponderance in the population, all of whom are intensely proud of their associations with Greece. The rest of the people are very largely Turkish, with a sprinkling of Arabs and Armenians and other Eastern Mediterranean folk. Practically all the women are small and dark, with good features. There is a marked contrast between the strapping country wench, who labours with the menfolk at the plough and in building and in road-making, and in the rather delicate, consumptive-looking town girl who dances with and otherwise "entertains" the troops in the so-called cabarets. Both Greek and Turk, in the country districts, wear characteristic costumes, the Greek girls wearing scarves round their heads, which are brought across the point of the chin, with the ends hidden away inside. They wear a local-made Russian type of boot, made of a good, soft leather. A short apron is worn over almost any type of dress, or blouse and skirt.

Often, even in elderly women, the hair is left hanging down the back, either loose or in a pair of plaits. The general effect, in front with the face framed completely in its circle of scarf, and behind with the hair streaming down below the point of the scarf, is very delightful. The Turkish women wear a less attractive head-dress, which consists of a combined cap and cape which finishes in a straight line at waist level. A band of material tied firmly across the centre of the forehead round the head holds the cap in place. This is usually a plain brown or green and is worn with a perfectly plain frock of the same material. It is the Turkish man who is the more picturesque of the sexes, for he wears the wonderful baggy breeches, which are enormous in width when spread out. All the fullness lies in great folds between the legs, drooping down nearly to the ankles, while the leg portion consists merely of a very short tube at the corner which accommodates the knee and finishes immediately below it. Stockings and shoes are worn. A broad sash is worn round the waist and a waistcoat or shirt above it, and around the head is tied a scarf. The general appearance is rather that of a brigand, especially as they frequently sport long moustaches. Many of the Greek men, incidentally, favour a tiny "Hitler" or "Charlie Chaplin" moustache, and wear modern clothes of loud "East End" patterns and cut. The other delightful character is the Greek priest in his black robes and high hat with the flat top, like an inverted "topper," and his long beard which gives him such a benign expression. There are so many priests, for in addition to the churches

there are monasteries dotted about in the mountains all over the island, some of which are very beautiful. I visited one or two and was always most graciously received and was invited in to rest and to partake of coffee and preserved cherries and suchlike delicacies. The churches within the monasteries and in the towns and villages are built mainly in a style which I cannot liken to any Western form of architecture. The towers are very small and house two or three bells, and the roof is steep, with a series of equal-sized and closely-adjacent gables running along the whole length of the sides. The most notable feature of the interior is the collection of ikons, which are mostly rather primitive paintings of saints and religious subjects. Although many of the Turks are Christian, the mosques form prominent landmarks in practically all the towns and villages, for their minarets are much taller than the stumpy little towers on the churches. The Turks had destroyed many of the ancient churches, and it is interesting, but woefully pathetic, to see magnificent ruins of cathedrals and churches, in places like Famagusta and Nicosia, with a minaret built on to the corner of the old tower and the whole place turned into a Moslem place of worship. Cyprus has seen so many vicissitudes and has been conquered and raided so often, that there are many ruins. In Famagusta, for instance, the old town, enclosed within its massive walls and battlements, is littered with hundreds of ruins, which give an idea of its former greatness. Over the triple-arched portal at the entrance to the palace of the kings is the black and white badge of the Lusignon family, which is similar to that of St. Bartholomew's Hospital. I tried to trace any connection, but failed to do so. The nearest I could get was the fact that the knights of Cyprus used to joust in tournaments held at Smithfield.

But to me, Cyprus is not represented by its towns with their city walls and the ancient ruins within them, but by the quiet beauty and friendliness of the country district known as Paphos, which forms the south-western corner of the island and where I spent much of my time. Here, between the sea and the white limestone hills and mountains behind us, we lived in a luxuriant belt of cultivated fields freely sprinkled with olive trees and caroub trees—the latter being the most characteristic, producing the black locust bean, much used for cattle cake, and, to a lesser extent, as a form of sweet and smelly food in the windows of tiny confectioners in back streets and village shops. This district is cut about freely by deep gorges and valleys, through which in winter, during

the rains, roared surging torrents, but which are dry at all other times of the year. In these fields and valleys, in the spring, flourished exceedingly all manner of wild flowers, of whose beauty I have already written with enthusiasm on many previous occasions. I have spoken of the cyclamen, the iris, the orchid, the anemone, hyacinth and many others, and have sketched crayon pictures of these and several lovely things which I could not identify. When we left, the fields were ablaze with poppies and marigolds. These sprawled together in gay patches, like happy lovers lying in the sun in our own green meadows, while other less blatant flowers kept to the paths and roadsides. Through this landscape, past our camp, wound the seemingly endless procession of peasant folk, mostly mounted on donkeys, who ambled slowly along, lost in their own thoughts, while behind, less willingly, came little groups of one or two black pigs and a few motley sheep and goats and a solitary cow, followed by an ancient Turk with a tall stick and a little home-made stool on which to rest periodically, a group of camels looking rather out of place in that setting, and showing in their expression that they, too, considered that they did not belong there at all. This constant procession, with its ever-changing variety of types, from the mother with her baby in front and a small child clinging on to her apron as he rides pillion on the three-seater donkey, to the pair of laughing girls similarly mounted, while old grandma trudges along with her pig, and the priest jogs along with his umbrella and Bible, never failed to delight me.

But I cannot let this picture of Paphos go without telling you a little of its history, for it was at one time the capital of the island. It was from the Rocks of Romeos—a lovely group just off the mainland—which figures in my sunset photograph, that Venus (Aphrodite) rose from the sea, and the Temple of Aphrodite is still in existence, though badly knocked about. All around the district are large groups of caves, many of which have been cut out to make caves and dwellings.

To Paphos came St. Paul, and there converted the Governor, Sergius Paulus, who thus became the first Christian ruler of any country. The district was so often raided by Arabs and others that there is little left of either Old Paphos, where the Temple stood, or of the New Paphos with its tiny harbour and Venetian tower. The churches were destroyed except for that of "St. Mary-in-the-Cloud" (or Church of the Shrouded Virgin), which was miracu-

## REPUBLICAN GERMANY

### *Medical Education before Hitler's Revolution.*

The main difference between the British and German universities is the fact that the latter are not divided up into colleges and medical schools.

The lectures on non-scientific subjects are given in the "Collegium-House," which also serves as the main administrative centre of the university. Practical classes in non-scientific subjects are held in the "Seminars."

The sciences are taught in the institutes, each of which is usually housed in a separate building. The preclinical student is thus concerned with the chemical, physical, botanical, zoological, and physiological institutes, and the "Anatomie." In that way he mixes with students of other faculties studying the same subjects. A medical student listening to a lecture on chemistry, for instance, might find himself in the same lecture room with students of dental surgery, veterinary surgery, pharmacy, chemistry, physics, agriculture, forestry, technical sciences, teaching profession, and others, whose curriculum includes that particular subject. It is obvious that the lecturer is in that way unable to satisfy the specific needs of the medical student, something that is possible at a British medical school. The practical classes in non-medical sciences, however, are usually specially arranged to satisfy the needs of the medical, dental, and veterinary students, who are also together in the physiological institute, although the veterinary students have their own anatomical institute.

The method of teaching is very similar to the methods of British medical schools. There are lectures, practical classes, and revision classes known as "colloquia." Histology is a part of anatomy, and is only held in the summer, dissecting being done only in the winter. Apart from chemistry and anatomy and histology there are practical classes in physiology and physiological chemistry. All the above classes are compulsory, whereas in physics, zoology and botany they are optional. The student must be signed up for the compulsory practical classes, and at some universities also for the compulsory lectures; at others it depends entirely on the student if he wants to attend the lectures or not, as long as he pays for them.

*Continued from page 6*

lously saved by being hidden by a cloud at the time. Most of the people went a mile or two

The academic year consists of two semesters, there being five preclinical and six clinical semesters. As the universities are all controlled by the government, it does not matter where one studies, and it is possible to go each semester to a different university. In that way it might be possible theoretically for a medical student to change his university eleven times, although it would obviously be unwise.

The examination in preclinical subjects is known as "Physicum." It contains chemistry, physics, botany, zoology, physiology and anatomy, and consists of long vivas in chemistry, physics, botany and zoology, and a practical and oral examination in physiology, and an oral examination in physiological chemistry. The examination in anatomy consists of a viva in histology with spotting and preparation of slides, the viva including questions on embryology, the dissection of an examination specimen, and an oral examination on dissected parts. There are no written examinations. The standard of the examinations is fixed by the government, and they are held at the beginning and end of every semester. In that way a student, who fails at the end of a semester, can take the examination again at the beginning of the next without losing a semester, although this may spoil his vacation. One can take an examination only twice, and the third time only with permission of the government. While this may have the advantage that a student will only enter for an examination if he has worked hard for it, it actually lowers the standard of the examination because an examiner cannot afford to be "out to plough" and will only fail somebody who knows absolutely nothing. The result of the "Physicum" as well as of the final examination is graded into very good, good, sufficient to pass, and failed. During one's preclinical days one is known as student of medicine, abbreviated "stud. med.", and during one's clinical days as candidate of medicine, abbreviated "cand. med."

The clinical subjects are the same as they are in this country, but the teaching is very different. It is done in the form of lectures, practical classes, and clinical lectures with demonstrations of cases, known as "kliniks,"

inland and built the little town of Ktima, which is now the market town and centre of the district.

J. R. B.

and outpatient classes, known as "polykliniks." Each subject is again taught in a different building. The clinical student is thus concerned with the pathological and pharmacological institutes, and the institute of hygiene, where bacteriology is usually taught. In addition, there are the surgical klinik, the medical klinik, the orthopaedic hospital, the nerve hospital, the skin and venereal hospital, the children's hospital, the women's hospital, the eye hospital, and the ear, nose, and throat hospital. Clerkships and dresserships are not compulsory, although it is a wise thing for the clinical student to do them during his vacations at the hospital of his home town. In that position he is known as "familus."

The student has, however, to live in during the semester to do his midwifery cases. At the end of the clinical course the state examination is taken, which consists of clinical and oral examinations and case reports, and includes also separate examinations in the special subjects.

After passing the state examination, the standard of which is again fixed by the government, the successful candidate is still far from being "qualified" or a "doctor."

He first has to take a compulsory house appointment for one year, known as the

practical year, during which he is known as the "praktikant" of medicine, abbreviated "med. prakt.", before he gets his qualification, known as "Approbation." The qualified practitioner is not permitted to call himself a doctor unless he holds a doctorate. The thesis is usually written during the practical year. If it is accepted, an examination in all branches of medicine has again to be taken, known as the doctor examination, the result of which is graded into *summa cum laude*, *magna cum laude*, *cum laude*, and *rite*.

In order to specialise appointments of five years in the speciality in question are required. The medical etiquette permits the specialist to put his speciality on his nameplate.

A specialist is allowed to lecture if he holds the "venia legendi" of a university. If he has been a lecturer for a certain number of years he gets the title of professor "extraordinary," while the professor "ordinary" corresponds to the British *regius professor*. Consequently, a continental specialist may be called "professor," while his British equal, or even superior, may only be plain "mister."

It will be seen that medical education is entirely controlled by the universities, which in their turn are controlled by the state.

## CORRESPONDENCE

In the last few seasons the number of spectators at Chislehurst has dwindled away to nothing—oddly enough the excuse generally offered is not the difficulty of travel, but rather that the matches are not advertised. In an endeavour to counter this, here is a list of the 1st XV. fixtures:—

Oct.	10—Welsh Guards	Away
"	17—St. Thomas' Hospital	Away
"	24—Middlesex Hospital	Home
"	31—St. Mary's Hospital	Home
Nov.	7—King's College Hospital	Home
"	11—Cambridge University	Away
"	14—New Zealand Air Force	Home
"	21—Aldershot Services	Home
"	28—London Hospital	Home
Dec.	5—Coventry	Away
"	12—Guy's Hospital	Away
"	19—O.C.T.U., Sandhurst	Away
"	26—Metropolitan Police	Home
Jan.	2—Northampton	Home
"	9—Rosslyn Park	Away
"	16—Wasps	Away
"	23—St. Mary's Hospital	Away
"	30—Public School Wanderers	Home
Feb.	6—Oxford University	Away
"	10—Cambridge University	Away
"	13—R.A.F., I.T.W.	Home
"	20—Bedford	Away
"	27—R.N.E. College, Keyham	Home
Mar.	6—King's College Hospital	Away
"	13—Nuneaton	Home
"	20—Middlesex Hospital	Away
"	27—Coventry	Home

From which it will be seen that we have several new and attractive fixtures at home, i.e., New Zealand Air Force, Nuneaton and Coventry, as well as the other hospitals. I hope that the stand will be full for all these games.

May I again ask any ex-player who still has a serviceable shirt to let me have it for club use.

J. H. GIBSON, Hon. Sec.

\* \* \*

### Books for Sale

The following books are for sale at Bart's Bazaar, Little Britain:—

The Edinburgh Stereoscopic Atlas of Anatomy, by Waterston and Burnet; Atlas of Clinical Diagnosis and Internal Diseases, by Jakob; Diseases of the Nervous System, by Gowers; Dictionary of Practical Medicine; Practical Treatment, by Musser and Kelly; Modern Technique in Treatment, by Lancet; Climates and Baths of Great Britain; System of Medicine, by Albutt and Rolleston; St. Bartholomew's Hospital Reports, Vol. LXVII., 1934; Clinical Pathology in Practice, by Thomas Horder; Common Disorders and Diseases of Childhood, by G. F. Still; Differential Diagnosis, by Cabot; Rousseau's Clinical Medicine; Principles and Practice of Medicine, by Osler and McCrae; Diagnostic and Therapeutic Technic, by Morrow; On Disorders of Assimilation and Digestion, by Sir Lauder Brunton; Diseases of the Heart, by James Mackenzie; A Text Book of Medicine, by Fagge and Pye Smith; and Nutrition and Disease, by Edward Mellanby.

## THE OBSTETRIC CASE WITH COMPLICATIONS

By H. MORRIS JONES

Mrs. K— L—, a housewife aged 32, was admitted to Paget Ward on 31st October, 1941, in the 32nd week of her first pregnancy.  
*Ante-natal History.*

This patient first attended the Ante-natal Clinic in the 20th week of pregnancy, and apart from her having diabetes mellitus, which was diagnosed 12 months previously, the pregnancy was considered to be progressing normally.

Before she became pregnant, the patient was living on a diet containing 220 G. carbohydrate, 90 G. protein and 110 G. fat, and her daily insulin requirement was 24 units ordinary insulin plus 22 units protamine zinc insulin, but as pregnancy advanced she needed an increasing amount of insulin.

On examination, when the patient was in the 28th week of pregnancy, the uterus was found to be larger than it should have been according to the duration of pregnancy—the abdominal girth being 40 inches. There was also œdema of the ankles but the blood pressure was normal and no albumen was found in the urine.

The presence of a twin pregnancy was suspected and a radiograph showed this to be the case. The patient was told to rest as much as possible.

Her next visit to the hospital was during the 32nd week of pregnancy, when she complained of shortness of breath and swelling of the ankles.

On examination her abdomen was abnormally enlarged—having a girth of 43 inches, this was thought to be chiefly due to hydramnios. In addition there was gross œdema involving both lower limbs, it included the feet, ankles and legs—reaching 1 inch above the knees. There was also marked œdema of the vulva, especially of the labia minora. Her blood pressure was still normal at 130/80, but there was albumen and sugar in the urine—the latter giving a yellow reduction of Benedict's solution.

The patient was admitted for rest and observation—her diet now containing 250 G. carbohydrate, she needed 36 units O.I. plus 34 units P.Z.I.

Four days after admission the œdema of the ankles and vulva had increased, her blood pressure had reached 150/90 and there was more albumen in the urine.

In an effort to reduce somewhat the swelling of the abdomen and the œdema of the lower

limbs, paracentesis of the hydramniotic sac was attempted. This procedure was not completed, however, as the appearance of blood suggested an anterior attachment of the placenta.

### *Complications*

The factors complicating the pregnancy were therefore:—

1. Diabetes mellitus, which was becoming increasingly difficult to control.
2. Hydramnios plus a twin pregnancy.
3. Oedema of the vulva—to a degree which would make delivery per vaginam difficult.
4. Toxaemia—increasing in severity—as shown by the rise in blood pressure and increase of albumen in the urine.

### *Treatment*

Thus in the interests of the mother, it was decided to deliver her by Cæsarian section although she was only 33 weeks pregnant. It was thought, however, that the babies, as they appeared of considerable size, would have a reasonable chance of survival in spite of their prematurity.

Two hours before operation 50 G. glucose were given to the patient, this was followed later by 1/100 grain atropine.

A classical Cæsarian section was performed under cyclopropane anaesthesia.

The placenta was found in the line of the uterine incision, it was divided, and the babies delivered with due speed.

Both babies were in reasonably good condition and soon cried lustily, the remaining part of the operation was uneventful.

### *Post-operative Progress*

The mother's post-operative condition was good, her insulin requirements were determined by noting the degree of reduction of Benedict's Solution by the urine.

On the 1st day after operation she received a fluid diet containing 250 G. carbohydrate.

On the 2nd day she was well enough to have a full diet.

On the 4th day she developed a temperature of 101° F. and her urine was found to contain *B. coli*. This was treated by giving potassium citrate until the urine was alkaline, followed by sulphamamide.

The insulin requirement had increased during the urinary infection, and when this had cleared up, the amount of insulin required varied

inversely as the amount of milk secreted by the breasts.

Gradually the patient's insulin requirement decreased and when discharged she needed only 28 units O.I. plus 14 units P.Z.I., which was much less than that required before delivery and approximated to her requirement before becoming pregnant.

#### *The Babies*

A few hours after birth the babies became generally oedematous, the oedema being most marked in the hands and feet, chest and eyelids.

The cause of the oedema was not known but was thought by Dr. Harris to be due to the toxæmia and also to be associated with the low blood sugar values.

These were 56 mgms.% and 96 mgms.% respectively—the baby with the lower blood sugar being the more oedematous.

To compensate for the low blood sugar each baby was given 1 G. glucose in  $\frac{1}{2}$  fl. oz. water, hourly by mouth. Within two days the blood sugar of both babies was normal, and the oedema of both had subsided, the more oedematous 7lb. 6oz. baby now weighing 6lb. 4oz. and the 5lb. baby now 4lb. 9oz.

Both babies were fed on breast milk and each received  $\frac{1}{8}$  grain thyroid extract daily for seven days. They continued to make very satisfactory progress and were discharged in good condition.

Two theories are advanced to explain the low blood sugar values in the case of the babies.

I. The foetal pancreas produces excess insulin to counteract the effect of the mother's hyperglycaemia.

As soon as the baby is leading an independent existence, it no longer requires this excess to keep its blood sugar normal. Nevertheless, the pancreas continues to secrete the same amount of insulin as before and as a result hypoglycaemia develops.

II. The insulin given to the mother may also act on the foetus producing a lowering of its blood sugar.

The former theory is thought to be the more likely, since the presence of the mother's insulin in the foetal circulation would reduce the activity of the foetal pancreas resulting in a post-natal hyperglycaemia.

#### *Commentary*

This case illustrates a number of factors complicating a pregnancy, and their effect on the babies.

It also shows the effect of pregnancy on diabetes mellitus controlled by insulin. Firstly, that an increased amount of insulin is required during pregnancy and secondly that the amount required after delivery is approximately the same as that required before pregnancy.

My thanks are due to Dr. Donaldson for permission to record this case.

## At HILL END

I sit down to write the last Hill End News that I shall ever write at a particularly opportune moment; for the cricket team have just won two matches in succession, and are even now still flushed with their victory—as well as with its traditional accompaniment. Indeed, everything seems to be going well at the moment. The play is progressing rapidly, and the work on the stage is being pursued with the usual energy. In fact, the choral society rehearsed the other night to the accompaniment of hammering from beneath the stage, so feverish is the activity.

Earlier this month, several people went out into the fields to help with the harvest, and their assistance was most welcome.

One of the lecturers recently remarked how odd it was that all the apples round about the

lecture room grew out of reach. Those of us who were near enough the front to hear what he was saying above the sound of apples being munched, are still puzzling over his meaning, which is not at all clear to us.

On Friday, September 11th, a most successful dance was held here, and we would like to congratulate the Band on its recent performances—not only is it possible to dance to their music, but it is also very pleasant to listen to.

And so I take my leave, and hand my pen to someone more competent to describe the comings and goings at this establishment; for the difficult part of the task is not to know what to say, but to be able to judge what cannot be included—and I wish him luck in his task.

## VICTORY TALES



BEER - GARDENING

*Choledo-deochus*

Some Herbert is needed—and needed soon. In the literature recently there has been a distressing tendency to refer to the bile duct by a name that sounds as if it were part of the apparently necessary accompaniment (lyric cit.) of a popular dance-tune. "Gentlemen, I am now exploring the choledochus. It contains contains multi-faceted liths, one of which is occluding the Ampulla of Vater where this is narrowed by the Sphincter of Oddi." "There's a rock bunging up the duct, old boy."

\* \* \*

*Where is Kiska?*

The tendency to fight in out-of-the-way places gives cartographers a headache. What atlas shows the Aleutian Islands? Look at America and you will see Alaska (inset) truncated at Bristol Bay; turn up Siberia and the same will be found in the top right-hand corner,

except that in addition it all seems to be nearly upside-down. The same goes for the Solomons. Here is new Guinea and something that looks like the edge of Bourgainville Island; and the annoying part is that if only Wales on the same scale wasn't occupying the corner, I'm sure the whole lot would be just there. Persia is, of course, always on the edge of two maps, and the bit of Libya that matters, or at least which used to matter, is completely missing. I suppose it just shows what mugs we all are.

\* \* \*

*Tail-piece*

In the treatment of shock  
it is better not  
to wait  
for Desoxycorticosteroneacetate.  
You get the same quota  
by boarding Doca.

\* \* \*

HOGARTH.

## CASUALTY IN WONDERLAND

They roused him with muffins — they roused  
him with ice—

They roused him with mustard and cress—  
They roused him with jam and judicious  
advice—

They set him conundrums to guess.

As they stood round his bed, with his hands  
on his head,

His history he sadly told,  
Of a lump that was soft, and blew out when  
he coughed,  
And of feet that were always too cold.

When he'd finished his tale, the Chief took it  
up,

And he spoke for an hour and five minutes,  
At the end of which time, there was heard, line  
by line,

This chorus of studious spirits :—

Atrophic, Ataxic,  
Pleuritic, Paretic,  
Erotic, Nephrotic—  
or puffy?

Ascorbic, Ascitic,  
Purpuric, Psychotic,  
Eccentric, Neurotic,  
or dotty.

There was silence supreme—not a râle, not a  
crep—

Scarcely even a rhonus or shiver,  
As the Chief they called Joe, in a voice full of  
woe,  
His judgment began to deliver.

" We must think of prognosis — eventual  
necrosis—

When our verdict we come to consider;  
Is it Page's Disease, or say what you please,  
Could it be a disease of his liver?

" Stenotic, Sclerotic, Nephritic, Necrotic,  
Or due to disease of the knee,  
Fibrotic, Cirrhotic, Dyspeptic or Toxic,  
Whatever the cause may be—

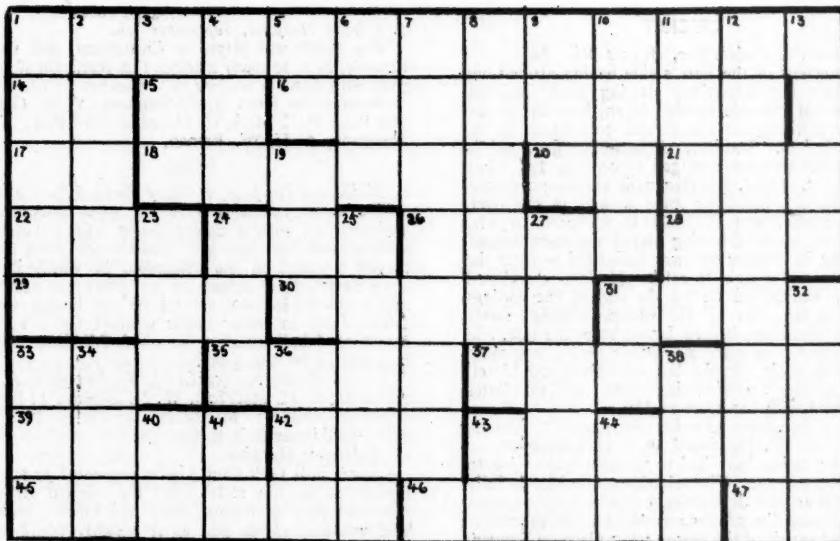
" The treatment is simple with modern tech-  
nique,  
Just diet, and fluids with tea;  
With a lot of cold meat, and some radiant heat,  
It's odd how much better he'll be! "

The firm stood amazed, by this discourse dazed,  
And indeed much too shaken to utter,  
But a man they called Pete was heard to repeat,  
In a scarcely definable mutter :—

Arthritic, Aplastic, Toxic, or Spastic; Dramatic,  
Sarcastic — or Butter?

D. V. B.

## NATURE NOTES



## THE CLUES

By PETER QUINCE

28/32rev, although the 3rev is still 31dn the East, 24dn/41rev are deserted; for our feathered friends 44/15rev/20 to ignore its command to 19rev/20 and be up and doing. 42rev hill and dale swoops the 6 bearing the Semipalmated Ringed 7 and one of his 5rev/41 Idn, the Sociable 35rev/11. She is a 10, dressed up to the 31dn rev/24dn, with plenty of 19rev/47. The pair is 24ac rev/40rev for the way it 34/44rev/20rev. A 21rev from New Zealand will 43dn/33dn rev them before the day 29rev; you see!

On the 40rev/47 of some fringed bathing-pool one glimpses the White Breasted Iac as he "proudly 18rev his 46 (*i.e.*, The 8 16/40rev Idn) before." What he does 4/44rev is

another 41/36rev. 31dn a creek nearby one 20/20rev the Great Crested 9/13/11. (His motto runs—"Per 27 ad Nauseam"), with the Long Billed 24ac rev/22rev—23/25 (or Ruddy 43ac rev Pecker). Each unpacks his 39—and his 5rev/44rev—from the 6 and 47/41rev down to it.

As twilight deepens one can 24dn rev/20 rather than see, 12 through the 31ac 17/24dn near Shepherd's Market, the unmistakable Long Tailed 4/44rev 37rev 45/11 (or British Oyster Catcher). No Swan of Avon is he, albeit a crow of 30rev/33ac rev; nevertheless he repeats his 24ac/20rev assiduously, and clucks with 44/26rev over the 14rev/40 41/36rev in his 2rev suitable for 47/38 only.

## GYNAECOLOGY FOR NURSES AND GYNAECOLOGICAL NURSING, by Sir Comyns Berkeley, M.D. (8th Edition, Faber &amp; Faber.)

This is a popular text book, and at 8s. 6d. is well worth the money. Gynaecology is a subject which nurses are apt to find more difficult than general medicine or surgery. The reason for this being, no doubt, that they do not get so much practical experience in this branch of nursing. A simple, well-illustrated text book is therefore most essential, and this edition of Sir Comyns Berkeley's book is to be recommended.

In the chapter on catheterization it is interesting to note that a glass catheter is preferred to a rubber one, and the method of procedure described is not that which is taught in this hospital.

It is stated in this book that dry sterilisation destroys rubber gloves more quickly than boiling them, though this is not a view that is universally held, and some recent experiments do not confirm it.

The questions given at the end are taken from State Examination Papers, and are always a helpful addition to a text book.

## SPORTS NEWS

## CRICKET

*v. Lensbury, at Teddington, August 9th. Lost.*

The nucleus of the Bart.'s side having arrived one hour after the advertised starting time, and the remainder of the side strolled in anything up to two hours late, the game commenced somewhere in the region of 4.30. Lensbury chose to bat first, and in between the showers managed to compile 124 for 9 wickets. J. Lucas, bowling with unerring accuracy, took 5 for 25, including three wickets in one over. W. D. Linsell was the only Bart.'s batsman who showed any signs of having played the game before, and going in number one was compelled to force the pace as he had a train to catch. He later abandoned this idea and batted on till the end of the innings for an excellent 58. J. H. Gibson, swinging freely from the shoulders, helped Linsell stem the tide, and brought Bart.'s in sight of victory before returning to his deck chair. In the last over Gray and Linsell fought against overwhelming odds, and the latter was bowled with the score at 116.

Scores: Lensbury 124 for 9; Lucas 5 for 25. Bart.'s: 116; W. D. Linsell 58, J. H. Gibson 17.

Recent matches have had to be scratched owing to insufficient support. The selection committee is fully aware of war-time difficulties, but still cannot understand the mentality of many of the club's members.

The last match of the season takes place on Sunday, September 13th.

## TENNIS

*v. Met. Police, at Chislehurst, August 29th.*

This match against the Metropolitan Police was the best Bart.'s have had throughout the season. The Police, as usual, turned out a very competent side, and although Bart.'s were not quite at full strength, the result was in doubt until the last match had been finished. The Police won by 5 matches to 4.

Results:—1st Pair: J. P. Stephens, Y. Y. Gabril, won 2, lost 1. 2nd Pair: E. Imossi, R. N. R. Grant, won 1, lost 2. 3rd Pair: R. B. McGrigor, J. Macaulay, won 1, lost 2.

## BIRTHS

**BARNES.**—On August 24th, 1942, at Allington House, Ipswich, to Margaret (née Nevile), wife of Capt. Clive Ormsby Barnes, R.A.M.C. (T.)—a daughter.

**BELL.**—On August 19th, 1942, at Junecroft, Orchard Way, Esher, to Hilda (née Faure), wife of Arthur C. Bell, F.R.C.S.—a son.

**BRODRIBB.**—On September 2nd, 1942, at Wye Bank Nursing Home, Buxton, to Renee (née Masterman), wife of Capt. H. S. Brodrribb, R.A.M.C., of St. Leonards-on-Sea—a son (Arthur John).

**DRUITT.**—On August 1st, 1942, at St. Bartholomew's Hospital, to Doreen, wife of Dr. A. W. Nigel Druitt—a son (Jason Nigel).

**DUFFY.**—On September 12th, at the Lucy Baldwin Maternity Hospital, Stourport-on-Severn, to Margaret Marianne Lucy (née Bowers), wife of Capt. C. A. Gavan Duffy, R.A.M.C.—son.

**FRASER.**—On September 6th, 1942, to Betsy (née Henderson), and Donald Fraser, F.R.C.S.—daughter.

**GOLDEN.**—On September 17th, 1942, at Grove House, Nursing Home, Norwich, to Diana (née Waterston), wife of Lieut. M. B. H. Golden, R.A.M.C.—a son.

**HANCOCK.**—On August 12th, 1942, at the Royal Bucks Hospital, Aylesbury, to Estelle (née Derouet), wife of Dr. F. R. Thompson Hancock, of Stoke Mandeville—a son.

**MCOWAN.**—On August 16th, 1942, at Bradley Moor Nursing Home, Wellington, Shropshire, to Margaret (née Backhouse), wife of Surg.-Lt. B. M. McOwan, R.N.V.R.—a son.

*v. London Hospital, September 5th.*

This match was played at Chislehurst, and, unfortunately, as in so many matches this year, rain stopped play with London leading by 2 matches to 1.

Team:—1st Pair: J. P. Stephens, Y. Y. Gabril. 2nd Pair: P. C. Mark, C. Manning. 3rd Pair: A. R. Anderson, A. H. W. Brennan.

## GOLF

*v. Middlesex Hospital, at Moor Park, August 22nd.*

The game was played in the most disagreeable weather, but with a determination and a keenness seldom seen on any golf course—the two teams played a round in the afternoon, in which Bart.'s were beaten by 5 games to 1. After an excellent and much-needed tea several of the bolder spirits sallied forth in rather better weather for a second round of 4 ball matches, in which Middlesex again beat Bart.'s by one game.

Team: P. Borrie (capt.), J. P. Stephens, A. R. Anderson, R. M. MacPhail, W. N. Ingham, T. Brady.

Result—Singles: Middlesex 5, Bart.'s 1. Four balls: Middlesex 2, Bart.'s 1.

*v. Middlesex Hospital.*

Crewes Hill Golf Club kindly consented to accommodate us for this match after the original arrangements to play at Porters Park had fallen through. The weather was as bad as it possibly could have been, and two members of the opposing side failed to appear owing to motor bike trouble on the way. Despite the adverse conditions, it was a surprisingly enjoyable afternoon, due to the extreme kindness of the members of the club. We should like to thank Mr. Randall for his extraordinary kindness during the afternoon.

Results: J. Smith 0, J. Pitts 1, 7/6; C. S. M. Stephen 1, G. Pitts 0, by default; A. R. Anderson 1, <sup>?</sup> by default; A. V. Livingstone 0, A. Joel 1, 3/2; J. Fison 0, E. Stumbles 1, 3/2; T. Brady 1, Du Quesne 0, 2/1; C. S. M. Stephen 0, Pitts and Pitts 1, 3/2; A. V. Livingstone and A. R. Anderson 1, Du Quesne and A. Joel 0, 2/1. Result, 4 matches each.

**REINOLD.**—On August 19th, 1942, at South Park Nursing Home, Sevenoaks, to Sylvia Noel (née Kelway-Bamber), wife of Surg.-Lt. Duncan G. Reinold, R.N.V.R.—a daughter.

## MARRIAGES

**ARMSTRONG—AUSTEN.**—On September 4th, 1942, at St. James's Church, Spanish Place, W.1, Dr. Richard Armstrong, M.D., F.R.C.P., to Alison Mary Austen, daughter of the late Major E. E. Austen, D.S.O.

**HEYLAND—POYNTON.**—On Friday, July 17th, 1942, at the Church of St. Bartholomew-the-Less, by Canon Leadbitter, Dr. Ralph Heyland to Joanna Poynton.

**LABOURNE—PIKE.**—On August 8th, 1942, at St. Michael's Church, Chester Square, London, Lieut. Maxwell N. Laybourne, R.A.M.C., only son of Mr. and Mrs. A. N. Laybourne, Singapore, to Dorothy Joan, only daughter of Mr. and Mrs. J. S. Pike, of "Whywoode," Marsh Lane, Stanmore.

## DEATHS

**BOWLE-EVANS.**—On August 23rd, 1942, at Applegarth, Cheltenham, Major-General Charles Harford Bowle-Evans, C.M.G., C.B.E., I.M.S., retired, aged 74.

**TELFER.**—On August 19th, 1942, Dr. A. C. D. Telfer, of 176, Howard Road, Walthamstow,